

FILED SEP 5 1950

STANDARD CERTIFICATE OF DEATH

State File No. 7234

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. LENGTH OF STAY (to this place) 18 YRS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		7059			
d. FULL NAME OF HOSPITAL OR INSTITUTION: 5907 WASHINGTON				d. STREET ADDRESS (If rural, give location) 5907 WASHINGTON					
3. NAME OF DECEASED (Type or Print) FRANCES ROSAMOND ANDERSON			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH (Month) (Day) (Year) 8-23-1950		5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH MCH 23-1870	
9. AGE (in years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CORINTH MISS.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME R. H. SHELTON			13b. MOTHER'S MAIDEN NAME ELSIE ROSAMOND			14. NAME OF HUSBAND OR WIFE FRANKLYN Y. ANDERSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME Elizabeth P. Sherman			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? A201					
22. I hereby certify that I attended the deceased from May, 1945, to Aug 23, 1950, that I last saw the deceased alive on Aug 22, 1950, and that death occurred at 4:30 P.M., from the causes and on the date stated above.									
23a. SIGNATURE Carl Brunel MD				23b. ADDRESS Webster Groves Mo		23c. DATE SIGNED 8/24/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 8-25-1950		24c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES CEM.		24d. LOCATION (City, town, or county) (State) ST LOUIS MO			
DATE REC'D BY LOCAL REG. AUG 25 1950		REGISTRAR'S SIGNATURE Dr B Fosater		25. FUNERAL DIRECTOR'S SIGNATURE Parker Aldrich ADDRESS Farm Home Web Groves Mo.					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Palmer Groves Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.